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ABSTRACT

The paper examines the meaning of transitional
objects and attachment to significant others in 18 severely retarded
children (mean age 5.2 years). Five case studies illustrate that the
use of objects and attachments can be seen as a normal phenomenon and
that often the children are responding appropriately to emotional
events with behaviors near or above their mental age. It is suggested
that emotional development should be evaluated as a separate entity
rather than an inevitable and pathological accompaniment to
intellectual deficits. (PHR)

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EMOTIONAL DEVELOPMENT IN SEVERELY
RETARDED CHILDREN

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Abstract

Play therapy with severely retarded children is an integral part of services offered by the Developmental Disability Center.

In the course of such therapies the authors have noted many indicators of normal emotional development in primitive children. A summary of these indicators in their therapeutic contexts is presented, and implications for the delivery of service to retarded children are discussed.

The incidence of emotional disturbance in retarded children has been noted to be higher than in the normal population (Philips and Williams, 1975, Simmons, Tymchuk, and Valente, 1974, Webster, 1970, Wilson, (1970). However, there has been little discussion of the normal aspects of emotional development in these children. It has been documented in studies by Weaver (1946), Shafter (1975), Tarjan, Dingman, and Miller (1960), and Windle (1962) that successful adjustment in mentally retarded individuals depends more on personality factors than I.Q. levels, per se. Generally, personality studies with the retarded have focused on the frustrations experienced by the mentally retarded child in his struggle to keep up with his intellectually normal peers. Those studies which have addressed emotional factors often utilized broad stereotyping which grouped all mentally retarded children together. Zigler (1973) and Chess (1970) note that, in their experiences, they have not found unique emotional characteristics which are invariably associated with retardation. Furthermore, Chess (1970) points out that mental age appropriate behavior is often misinterpreted as deviant, resulting in attempts to eliminate or alter relatively normal emotional reactions deemed acceptable in chronologically younger children.

While a greater percentage of retarded children do have psychiatric problems (Menolascino, 1970), the evidence suggests that the kinds of symptomatology exhibited do not differ significantly from those exhibited by non-retarded children with psychiatric disturbances.

Simmons et.al. (1974) point out that it is often assumed that the retarded person does not have the same level or intensity or emotional reaction as the normal person. However, they apply their description only to mildly and moderately retarded individuals. The absence of discussion leaves one the impression that severely retarded children have no emotional life. Evidence exists that such children do demonstrate behaviors which appear to reflect normal emotional reactions.

This paper describes the use of transitional objects and attachment to significant others by severely retarded children. These behaviors are seen as indicators or milestones in the emotional development of normal children but are often misperceived or ignored in the retarded, often with attempts to behaviorally shape this reaction out of existence.

Description of Sample

This paper is based on sample of 18 children ranging in chronological age from 2 years 4 months to 9 years 6 months with a mean age of 5.2 years. Measured I.Q. scores ranged from 25 to 72 with 5 children being untestable. Using the AAMD Adaptive Behavior Scale, 10 children were at Level V (Profoundly handicapped AB), 3 were at Level IV (severely handicapped AB), 1 was at Level III (Moderately handicapped AB), 2 were at Level II (Mildly handicapped AB), 2 were at Level I (mildly in normal limits).

• The events to which our sample responded with behaviors suggestive of normal emotional reactions included:

<u>Behavior</u>	<u>Number of Children</u>
Reaction to birth of sibling	3
Attachment to therapist	8
Reaction to environmental change (home, school)	4
Reaction to separation	3
Use of transitional object	4
Reaction to depression of parent	2
TOTAL	24 ^a

^aMore than one of the reactions were observed in some children.

To illustrate the qualitative aspects which we are addressing five cases will be presented in some detail.

Case #1

Shan D., referred at age 8, was diagnosed as profoundly mentally retarded and psychotic. He was considered generally "untestable" and on no instrument had he received an I.Q. higher than 35. The unique portion of his developmental history included a strong attachment to a coat hanger beginning around one year of age. It was the only object that he consistently related to or seemed to care about. He would put hangers in his mouth and "twang" them, break them into pieces, and carry them around with him wherever he went. Upon his admission to an institutional setting, an attempt was made to remove the hanger using behavior modification techniques. S.D.'s response was an immediate onset of self-destructive behaviors (pulling hair, pulling skin off his fingers, rocking and head banging, etc.) When the hanger was returned, these behaviors ceased. In an intensive diagnostic study of the use of the hanger, S.D. was observed to demonstrate the following capacities:

- (1) He immediately looked for hangers in any new surrounding and could remember where they had been placed in familiar rooms.
- (2) If a hanger was not available he would crook his forefinger into a "hanger" shape.
- (3) He would respond to a picture of a hanger as if it were real and would physically indicate that he wanted a hanger drawn.
- (4) He broke a hanger into small pieces and constructed small hangers out of them.
- (5) His only speech was an attempt to say "hanger."
- (6) Most of his affective expressions occurred during hanger play.

After S. D. had regained possession of his hangers and other interventions were instituted, he gradually reduced his investment in hangers and broadened his behavioral skills to many more "normal" objects. His use of the hangers, characterized by professionals as deviant, had actually been quite similar to the typical teddy bears and blankets of small children, and indeed occurred during the appropriate developmental period. Although his usage of the hangers extended over a longer period than most uses of transitional objects, the quality of his play and reactions to the loss of the hangers indicate that they served the same purpose as in normal children, i.e., an object around which there are structured

symbolizations which are relied upon for emotional reinforcement and support.

Case #2

Erin C., referred at age 4 years, was diagnosed as being severely emotionally disturbed. She exhibited many autistic behaviors and proved to be very resistant to standard testing. Her performance indicated uneven development, with some above age level skills such as reading and yet with some failures at very early levels. Her use of language was inappropriate and usually non-communicative. She often echoed what she had heard in the exact tone in which she had heard it.

Around age 2, E.C. began to exhibit very rigid, compulsive behaviors and began to show attachment to various types of cosmetic items including tubes of lipstick and toothpaste, hair brushes and mascara brushes, etc. She would insist on carrying these objects everywhere with her and would not leave the house without at least one of the objects. As she grew older, she began to substitute pictures of the objects, torn from magazines, when the object was not available. Eventually, she became able to pick out the printed word for the item and would carry that around when the item itself was not available. At age four, she could recognize and cut out words such as toothpaste, mascara, etc., and brand names which represent such items, i.e., Crest, Maybelline.

E.C.'s attachment to these items reached a point where neither she nor her parents were going out of the house due to

her, extreme tantrum behavior if separated from her attachment objects. With the aid of a shaping program, E.C.'s parents were able to shape E.C.'s attachment behavior into acceptable forms. This shaping program, unlike the program used earlier with Shan, included substitutions and ways to move the behaviors into socially acceptable forms rather than removal of the objects. Her mother was able to have certain places where the attachment object would be left when E. left the house and to allow her to carry only one reasonably sized object. This shaping continued with a hair brush until E.C. carried around only one bristle from the brush for a time and finally extinguished the behavior altogether.

Case #3

Sean B., age 3 years 10 months, was a child suffering from a severe seizure disorder and considerable developmental delay. He could not respond to any type of evaluation and was considered to be profoundly retarded. He had no speech, no self-help skills, and extremely poor motor coordination. S.B. was seen in intensive, intrusive play therapy over a period of several months. The therapy utilized physical intervention to increase self-awareness, promote a social relationship, encourage goal-directed activity, and stimulate emotional development (Leland and Smith, 1965). Over several months, S.B. gradually improved his motor skills so that he no longer fell, established and maintained eye contact, sought out his therapist for comforting, attempted to structure some play, ceased mouthing objects, and developed some play skills. At this point in his development a sister was born to the family.

Beginning with the next therapy session, S. B. "lost" his physical coordination, laid on the floor, crawled rather than walked, increased his mouthing of objects, and sought hugging and physical comforting. On the first occasion that his baby sister accompanied him to a play therapy appointment, S. B. ran away and attempted to tear up objects when his therapist interacted with his sister. These behaviors persisted for several sessions and then gradually diminished, with S. B. eventually regaining and surpassing his therapeutic accomplishments.

The occurrence of the regression was attributed generally to the birth of a sibling, and followed a somewhat similar pattern to those expected in therapy with more "normal" children of a similar age. S. B. later developed a primitive social relationship with his siblings and did not regress again.

Case 4

E. E., age 8, had received a diagnosis of profound mental retardation accompanying a seizure disorder. E. was considered generally "untestable" as he could not be conditioned to a testing situation. At no time has he tested higher than 1½ years developmentally on any instrument. One of the behaviors which his teachers and family were intent upon extinguishing was putting his hands in his mouth. At one time in his early life he was in a special school where his arms were put in splints in order to keep him from reaching his mouth. At this time, he does not feed himself and physically resists self-help instruction in feeding. There

is a question as to whether he does not reach his mouth because of spasticity, conditioning (splints) or emotional factors. His teachers now have remarked that he does not seem to know his arm is attached to him or that he has any control over it.

Although E. has rarely shown even the most minimal recognition of family members, has no expressive language and does not react to pain, he has exhibited an awareness of family events. Following the birth of his sister when he was 7½, E. began to exhibit regressive behavior. He started to scoot about on the floor rather than walk, to make grunting sounds and to have toileting accidents when his mother nursed the baby. His parents had had less time to interact with him, and his mother was absent during the birth hospitalization.

It was not until the parallel between changes in the parents' behavior and E.'s reactions to these was pointed out to the mother and she was instructed to spend as much time alone with him as possible that E. did in fact stop scooting, grunting, and wetting himself.

Case 5

E. B. was a 4-year-old female with multiple and severe handicaps, including prematurity, cleft plate, mild hemiparesis, and severe head-banging and other self-abuse. She had received a diagnosis of chronic brain syndrome with psychosis associated with congenital cerebral defect. Several psychological evaluations recorded

her highest I.Q. as 28 and adaptive behavior scale percentiles below 50. When E. B. was placed in an institutional setting, she engaged in continuous head banging and biting, avoided social contact, and was severely delayed in motor coordination. An intensive behavioral program with multiple interventions was initiated, focusing mainly on cuddling, social interaction, and tactile stimulation. Positive effects of the intervention included E. B.'s reaching for familiar staff members and laughing appropriately.

At this point several significant events occurred. E. B.'s major therapist, a nurse, left the hospital. E. B. responded by a return and increase of head banging, kicking, biting, and loss of eye contact.

After a two week home visit, E. B. returned to the institutional setting, when her maladaptive behaviors increased in intensity. On the mistaken assumption that the home visit was responsible, E. B. was not allowed to return home, wherein her behavior deteriorated further (e.g., refusing to eat). After emergency consultation, the home visits were resumed, and E. B.'s behavior became a "Monday" phenomenon, i.e., an angry reaction to separation. A combination of intensive social interaction with E. B. on Mondays and a concurrent emphasis on increased parent involvement in both supportive counseling and E. B.'s actual treatment program resulted in a rapid and marked improvement. E. B. gained sufficiently to be returned home and entered into a day care program.

* Thus, an event common to normal children (reaction to separation from important parental figures) was not initially recognized as applying to a severely retarded child. When this did occur, introduction of similar interventions to those used with "normal" children resulted in a rapid and significant improvement.

Conclusions

Bialer (1970) has concluded that mental retardation and emotional disturbance are not causally related. In any particular retarded child, there of course may be sensory and integrative disturbances that alter the child's view of reality and increase the chances of disturbance (Menolascino, 1970). However, also occurring in any history are environmental variables such as the reactions of parents, caretakers, and social environments. For example, there is a higher incidence of disturbed children among institutionalized retarded children, but this occurs within a peculiar social and emotional environment. In the home environment we may find over-stimulation, confused expectations, withdrawal of emotional involvement, infantilization, or outright deprivation. Since there is no firm evidence that siblings of retarded children are less well adjusted than those of normal children (Simmons et.al, 1974), it may be that the specific expectations parents have of retarded children may cause a denial of basic emotional experiences to retarded children because of their other (intellectual) deficits.

Whereas many therapeutic efforts with retarded children focus on eliminating overt behaviors which negatively affect

the physical or social environment, our purpose has been to examine the environment's inner meaning to the child and the affective experiences associated with the child's development as a normal phenomenon. Our findings with severely retarded children suggest that in many cases these children are responding appropriately to emotional events with behaviors near or above their mental age. This suggests a need to evaluate emotional development in the retarded as a partially separate entity rather than an inevitable and pathological accompaniment to intellectual deficits.

Implications for clinical training and the service delivery system

1. For the most part, psychiatric training programs include little information about retardation (Simmons, et.al. 1974), while psychologists are generally involved in intellectual measurement and the design of behavioral programming for educational purposes. The evidence noted in this paper suggests the following needs:
 - a. Psychiatry and psychology training programs should place more emphasis on translating current knowledge about normal emotional development into skills in the evaluation and treatment of severely retarded children.
 - b. Psychotherapy should be considered as a legitimate treatment alternative for these children.
 - c. Teacher training programs need to increase awareness of normal emotional development, and methods for

integrating this knowledge into the classroom should be developed.

- d. Parents of retarded children can have considerable positive influence on their children's emotional development if they have available the knowledge and support of a system which can demonstrate the normal emotional needs and responses of the retarded child, and which can help them adjust their own sometimes maladaptive assumptions about their capacity to aid the child's development.
- e. The emotional life of the retarded child should receive closer scrutiny at every step of the intervention process. Before institutionalization is even considered, a comprehensive evaluation of the emotional quality of the home environment is indicated, including the presence of transitional objects and interpersonal attachments. Should residential placement become necessary, careful planning is needed to anticipate the emotional impact of the environmental change and to effect a smoother transition by including as many supportive elements as possible from home, family, and other interpersonal relationships. Once a child is placed in a residential setting, a milieu should be created which fosters normal emotional development and provides increased opportunities to benefit from close human relationships.

REFERENCES

- Beier, D. Behavioral disturbances in the mentally retarded.
In H. Stevens and R. Heber (eds.) Mental Retardation: A
Review of Research. Chicago: The University of Chicago
Press, 1964.
- Bialer, I. Psychotherapy and other adjustment techniques with
the mentally retarded. In A. Baumeister (ed.), Mental Retardation.
Chicago: Aldine, 1967.
- Bialer, I. Emotional disturbance and mental retardation: etiologic
and conceptual relationships. In F. Menolascino (ed.),
Psychiatric Approaches to Mental Retardation. New York:
Basic Books, 1970.
- Chess, S. Emotional problems in mentally retarded children.
In F. Menolascino (ed.), Psychiatric Approaches to Mental
Retardation. New York: Basic Books, 1970.
- Cytryn, L. and Lourie, R. S. Mental retardation. In A. M. Freedman
and H. I. Kaplan (eds.), Comprehensive Textbook of Psychiatry.
Baltimore: Williams and Williams, 1967.
- Gumz, E. and Gubrium, J. Comparative parental perceptions of
a mentally retarded child. American Journal of Mental Deficiency,
1972, 77, 175-180.
- Leland, H. and Smith, D. E. Play Therapy with Mentally Subnormal
Children. New York: Grune & Stratton, 1965.

Menolascino, F. Psychiatric Approaches to Mental Retardation.

New York: Basic Books, 1970.

NewComer, B. L., and Morrison, T. L. Play therapy with institutionalized mentally retarded children. American Journal of Mental Deficiency, 1974, 78, 727-733.

Philips, I. and Williams, N. Psychopathology and mental retardation: A study of 100 mentally retarded children: I. Psychopathology. American Journal of Psychiatry, 1975, 132 (12, 1265-1271.

Shafter, A. J. Criteria for selecting institutionalized mental retardates for vocational placement. American Journal of Mental Deficiency, 1975, 61, 599-616.

Simmons, J. Q., Tymchuk, A. J., and Valente, M. Treatment and Care of the Mentally Retarded. Psychiatric Annals, February, 1974, 4:2, 38-39.

Tarjan, G., Dingman, H. F., and Miller, C. R. Statistical expectations of selected handicaps in the mentally retarded. American Journal of Mental Deficiency, 1960, 65, 335-341.

Thomas, A., Chess, S., and Birch, H. G. Temperament and behavior disorders in children. New York: New York University Press, 1968.

Weaver, T. R. The incidence of maladjustment among mental defectives in military environments. American Journal of Mental Deficiency, 1946, 51, 238-246.

Webster, T. G. Unique aspects of emotional development in mentally retarded children. In F. Menolascino (ed.), Psychiatric Approaches to Mental Retardation. New York: Basic Books, 1970.

- Wilson, W. Social psychology and mental retardation. In N. R. Ellis (ed.), International Review of Research in Mental Retardation (Vol. 4) New York: Academic Press, 1970.
- Windle, C. Prognosis of mental subnormals. American Journal of Mental Deficiency Monograph Supplement, 1962, 66, (5).
- Zigler, E. Research on personality structure in the retardate. In N. R. Ellis (ed.), International Review of Research in Mental Retardation. (Vol. 1) New York: Academic Press, 1966.
- Zigler, E. Familial mental retardation: A continuing dilemma. Science, 1967, 155, 292-298.
- Zigler, E. The environmental mystique: Training the intellect versus development of the child. Childhood Education, 1970, 46 402-412.
- Zigler, E. Symposium paper. In Routh, D. K. (ed.), Experimental Psychology in Mental Retardation. Chicago: Aldine, 1973.